MHS Business Planning Update

"Translating Strategy into Action"

Tri Service Symposium

13 July 2006

MHS Business Planning Workgroup

MILITARY MEDICINE TRANSFORMING THE FUTURE

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Agenda

- Why Business Planning?
- Background
- MHS Strategic Transformation
- Current Status
- Critical Initiative Development
- Why Facilities?
- FY08-FY10 Business Planning Cycle
- MILCON Planning Vs. Business Planning
- Analytic Components
- PPS Approach
- PPS relationship to Business Planning
- Facilities Business Planning Horizon
- Questions

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Why Business Planning?

- Need to be able to forecast health care needs and purchased care requirements
- Coordinate care in multi-market regions
- Place accountability for care at MTF
- Quantify deviations from plan
- Base budgets on outputs, not inputs
- Justify budget

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Background

- Planning, resourcing, execution and performance monitoring have historically operated as separate functions within the MHS
- ***To accomplish the mission effectively,*** these functions must be integrated
- Since 2004, the MHS has made a concerted effort to:
  - **Integrate the processes supporting the business planning function across the enterprise**
  - **Link business planning with resourcing, execution, and performance monitoring**

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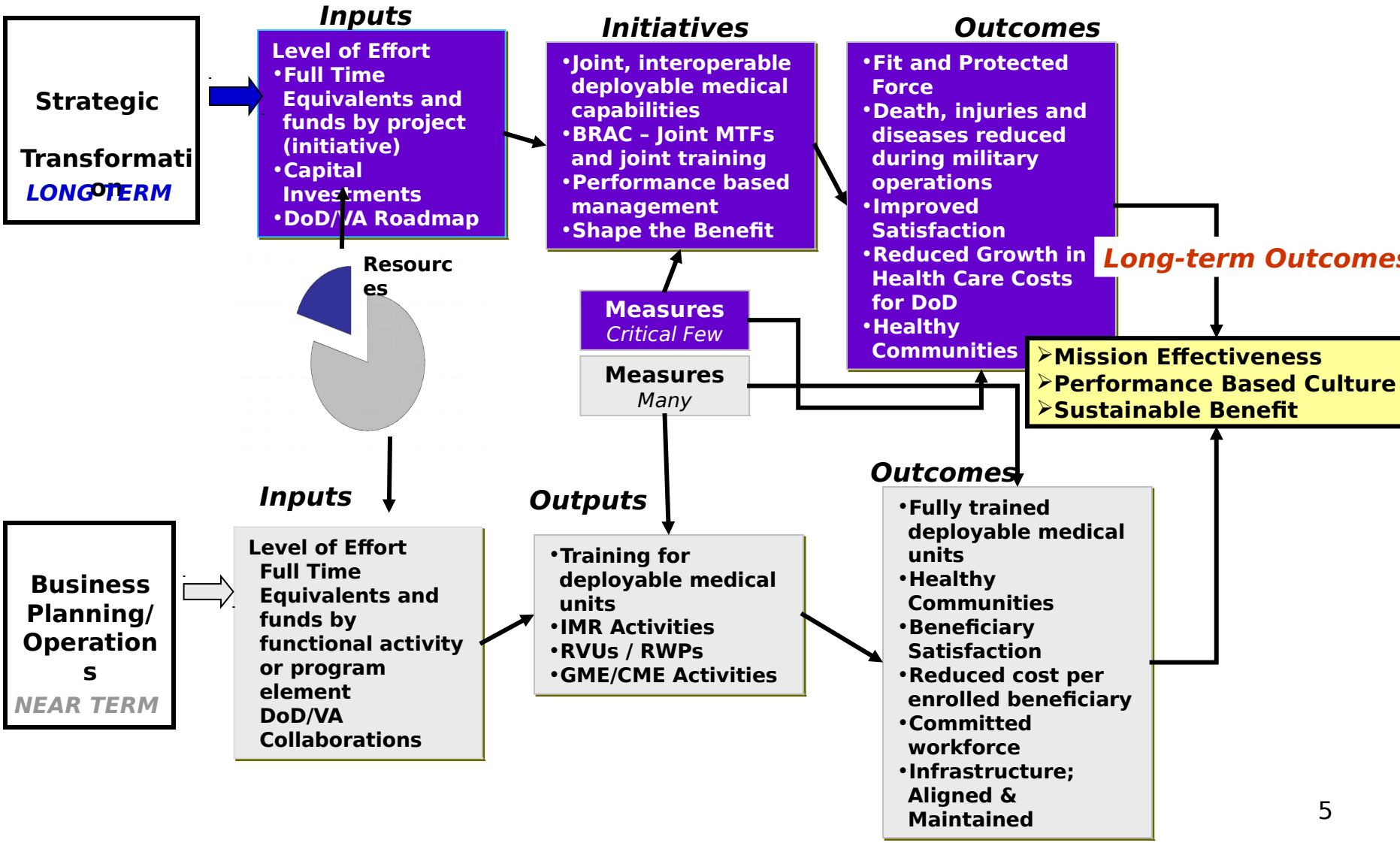
Integrating MHS Strategic Transformation and Business Planning



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Current Status

	06-08 Planning Cycle	07-09 Planning Cycle
WG Tool	▫ Dynamic prototype, TriService Direct Care Focus	▫ Stabilized, TriService Direct Care Focus, Unified approach
PPS	▫ Informal, SG-directed	▫ Chartered BP Workgroup
Schedule	▫ Portion of resources linked to Plan and Execution at HA level	▫ Greater portion of resources linked to Plan and Execution
	▫ Driven by Purchased Care contracting cycle	▫ Driven by POM cycle and link to resources
Training	▫ Service-specific, Tool-focused	▫ Service-specific & Market focused

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Critical Initiative Development

- Eight Critical Initiatives of the MHS Strategic Plan
  - Access to Care
  - Referral Management
  - Documented Value of Care
  - Labor Reporting
  - Pharmacy Management
  - Evidence Based Health Care
  - Provider Productivity
  - Contingency Planning
- Critical Enablers
  - Facilities Management
  - Equipment Management
  - Venture Capital

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Why Facilities?

- We must link facilities to the enterprise
  - Infrastructure is not factored into MTF Business Planning process
  - MTF Commanders do not have ability to value/size their facilities
  - We lack a comprehensive listing of assets
  - We lack the ability to determine facility capacity and productivity
  - We lack ability to link facility investments with performance goals articulated in business planning

- QDR – 8 "Transform the Infrastructure"
  - Asset visibility
    - Physical & functional condition
    - Process to measure facility condition improvement
  - Link facility investments with performance goals
  - Transform MILCON process

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FY08 – FY10 Business Planning Cycle

- Begin to obtain visibility of MHS MTF portfolio by shadowing DMLLS
  - New facility component fields in Business Planning Tool
    - Number of exam rooms (by department)
    - Number of inpatient beds
      - Designed
      - Reported
- Introduce facility questions in the BPT
  - Is the amount of clinical treatment space sufficient to allow the desired amount of direct care workload?
  - Does the configuration of clinical space allow the desired level of staff productivity?
  - Are you purchasing care due to insufficient space?
- Develop facility questions for MHS survey use
  - What do our customers think of our facilities?

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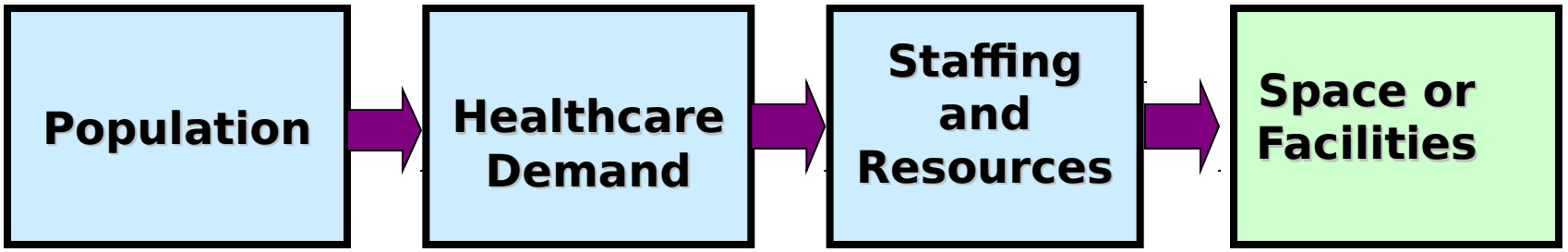
MILCON Planning Vs. Business Planning

- Health Care Requirements Analysis (HCRA) and Market-Based Business Planning are aligned in intent but differ in execution

"A systematic, quantitative approach to allocating healthcare resources based on the size and demographic characteristics of a population measured against viable alternatives."



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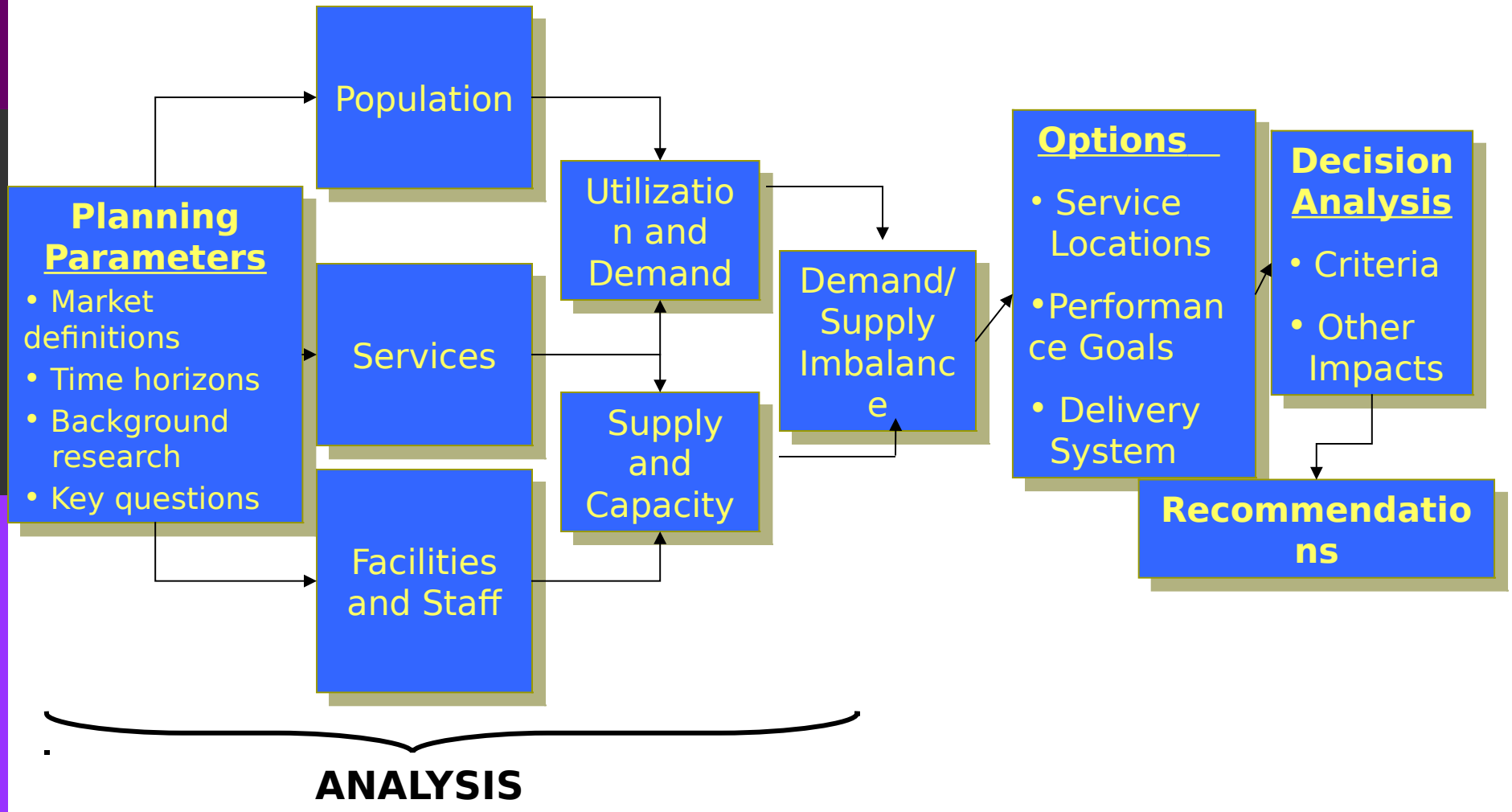
Analytic Components for HCRA and Business Planning Should be Congruent



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A Prospective Payment Approach

- Direct care costs taken directly from M2
- But, PPS FFS reimbursement rates used in EA as relevant future costs to the system, vice current recorded costs
- Key assumption: PPS FFS values of future workload output is best measure of system costs going forward (What TMA will pay for care delivered)
- PPS-based cost estimates in test case EA were significantly lower than actual cost-based estimates

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A Prospective Payment Approach

		Bed-days		Dollars	
Patient Location	**Product Line**	**Total**	**ICU**	**Full Cost**	**PPS Earnings**
In Catchment	Medicine	5,155	523	11,353,424	8,797,449
	Surgery	4,781	1,536	19,050,469	15,407,556
	OB/Newborn	3,296	915	9,955,285	3,538,727
	Mental Health	89	5	200,506	45,644
In Total		***13,321***	***2,979***	***40,559,684***	***27,789,376***
Out of Catchment	Medicine	1,002	98	2,176,804	1,698,814
	Surgery	1,914	502	6,604,675	4,915,452
	OB/Newborn	574	227	1,630,382	735,416
	Mental Health	26	1	51,571	13,570
Out Total		***3,516***	***828***	***10,463,432***	***7,363,252***
Grand Total		**16,837**	**3,807**	**51,023,116**	**35,152,628**

PPS reimbursement value ≈31% < Current Full Cost

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PPS Relationship to Business Planning

- Funds MTF's based on business plan outputs (currently blended)
- Inpatient
  - Relative Weighted Products (RWP's)
  - Mental Health bed days
- Outpatient
  - Relative Value Units
- Quantify deviations from the plan
- Bases budgets on outputs, not inputs

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Facilities Business Planning Horizon

- Reconcile DMLLS and MEPERS
- Develop capacity/thru-put
  - RVU per square foot
  - By exam room
- Provide MTF's ability to determine proper department sizing
- Provide MTF's ability to reconcile currently reported capacity with infrastructure capacity (ranges)
- Develop ratio ranges for non-earning revenue space and revenue earning space

Questions

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